HOOPA VALLEY TRIBAL COUNCIL
(WORKERS COMPENSATION PROGRAM)
REFERRAL FOR MEDICAL CARE

NAME OF EMPLOYEE	
DEPARTMENT/ENTITY	DATE
M.D. TO WHOM EMPLOYEE IS REFERRED	
REFERRAL FOR TREATMENT OF:	DATE AND TIME OF INQUIRY
REMARKS BY EMPLOYEE SUPERVISOR/REPRESENTATIVE	
SIGNATURE OF EMPLOYEE/SUPERVISOR REPRESENTATIVE	

PLEASE COMPLETE AND RETURN LOWER HALF OF FORM

TO EMPLOYER

NAME OF EMPLOYEE	
DATE EMPLOYEE UNDERWENT TREATMENT	
DIAGNOSIS	
TREATMENT RENDERED	
REMARKS BY M.D.	
MAY RETURN TO WORK	LIMITATIONS
{ } REGULAR { } LIMITED	
CARE TO BE RENDERED OR ADDITIONAL INSTRUCTIONS	
DATE OF APPOINTMENT FOR FURTHER TREATMENT	
MAY NOT RETURN TO WORK UNTIL THE DATE SPECIFIED	
SIGNATURE OF MEDICAL DOCTOR	

NOTICE TO DOCTOR: PLEASE FORWARD YOUR FIRST REPORT TO TRISTAR RISK MANAGEMENT IMMEDIATELY.